PHARMACIST'S INFORMATION FORM
Drug Therapy Management

Each pharmacist who is to perform drug therapy management under this Physician-Pharmacist Agreement must complete a Pharmacist Information Form. The purpose of the form is to provide information to t he Board of Pharmacy so that the Board may determine if each pharmacist has the basic qualifications to perform under this Physician-Pharmacist Agreement. The Board of Pharmacy must approve each pharmacist.

Pharmacist's Name_____
Last First Middle Generation (Sr., Jr., etc.)

1. Status of Pharmacist's License.

A. License Number:_____

B. □ I have not had a public final order disciplining my pharmacist's license within the 5 years immediately preceding this application. If you have had a public final order disciplining your pharmacist's license within the 5 years immediately preceding this application, please stop here. You are not eligible to provide drug therapy management.

□ I was disciplined by the Board of Pharmacy more than 5 years ago and currently my license has limitations place on it. If you indicated that you currently have limitation placed on your pharmacist's license, please stop here. You are not eligible to provide drug therapy management.

2. Education and Training.

Please feel free to attach an additional document if more space is required to answer the following questions. Be sure that you make clear which answer accompanies which question.

□ I possess a Doctor of Pharmacy degree. (If you checked this box, please skip to section 3.)

School from which degree obtained:_____

Year that degree was obtained:_____

□ I possess a Bachelor of Science in Pharmacy degree and I have training in the areas listed below. I am providing documentation for each item listed below and/or an explanation.

A. Designing, implementing, monitoring, evaluating, and modifying or recommending modifications in drug therapy to ensure effective, safe, and economical patient care.

B. Identifying, assessing, and solving medication-related problems, and providing clinical judgments as to the continuing effectiveness of individualized therapeutic plans and intended therapeutic outcomes.

C. Conducting appropriate physical assessments, evaluating patient problems, and ordering and monitoring medications and laboratory tests in accordance with established standards of practice.

D. Monitoring patients and patient populations regarding the purposes, uses, effects, and pharmacoeconomics of their medications and related therapy.

E. Providing emergency first care, including cardiopulmonary resuscitation.

F. Using clinical data to optimize therapeutic drug regimens.

G. Documenting interventions and evaluating pharmaceutical care outcomes.

H. Integrating national standards for the quality of health care.

3. Advanced Training.

Please indicate that you possess or have completed at least one of the following and attach any necessary documentation:

□ I currently possess a certification from the Board of Pharmaceutical Specialties;

Type of Certification:_____

Date Awarded: _____ Expiration Date: _____

□ I currently possess a certification from the American Society of Consultant Pharmacist's Certified Geriatric Practitioner certification program;

Date Awarded: _____ Expiration Date: _____

□ I currently possess a certification from a program approved by the Board of Pharmacy;

Name of Program_____

Date Awarded: _____

□ The certification program is not currently approved by the Board of Pharmacy. I am submitting information to the Board of Pharmacy and am requesting evaluation and approval of the program from which I possess a certification.

Name of Program_____

Date of Program: _____

□ I have successfully completed a residency offered by a body accredited by the American Council on Pharmaceutical Education; (accrediting bodies for residencies include organizations such as the American Pharmaceutical Association and the American Society of Health-Systems Pharmacists)

Name of body accredited by the American Council on Pharmaceutical Education:

_____

Date of completion of residency:_____

Type of residency:_____

Location or locations where residency performed:_____
_____
_____

□ I have successfully completed a residency that was approved by a body approved by the Board of Pharmacy.

Name of body approved by the Board of Pharmacy:

_____

Date of completion of residency:_____

Type of residency:_____

Location or locations where residency performed:_____
_____
_____

□ I have successfully completed a National Association of Boards of Pharmacy credentialing examination.

Name of Credentialing Examination:_____

Year When Credentialed:_____

□ I have successfully completed a credentialing examination approved by the Board of Pharmacy.

Name of Credentialing Examination:_____

Year When Credentialed:_____

□ The credentialing examination is not currently approved by the Board of Pharmacy. I am submitting information to the Board of Pharmacy and am requesting evaluation and approval of the program from which I possess a certification.

Name of Program_____

Date of Program: _____

4. Hours of Experience (Please check at least one).

Either 1,000 hours of relevant clinical experience or 320 hours of structured experience in a program approved by the Board of Pharmacy is required.

□ I have successfully completed 1,000 hours of relevant clinical experience. Please explain and attached any supporting documentation.

_____
_____
_____

□ I have successfully completed 320 hours in a structured experience program approved by the Board of Pharmacy. Please explain and attached any supporting documentation.

_____
_____
_____

5. Signature.

By signing this Pharmacist Information Form, I am requesting that I be approved to perform drug therapy management pursuant to the accompanying Physician-Pharmacist Agreement and protocol or protocols. I solemnly affirm under the penalties of perjury that the contents of this application are true to the best of my knowledge, information, and belief.

_____
Signature Date